Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLAN J CHERNOV MD
P O BOX 121589
ARLINGTON TX 76012

Respondent Name

SOUTHERN VANGUARD

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-12-2289-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this case the reimbursement is not according to the rule. The Designated Doctor may conduct two distinct exams in the same day. He shall be reimbursed $350.00 per exam. The procedural guidance for bundling of codes does not apply to Designated Doctors exams. The examination for MMI/IR is reimbursed at $350.00 and $150.00 for one body area (DRE) method. When a permanent impairment exists, A Division of Workers' Compensation (DWC) certified impairment rating (IR) doctor must perform a physical examination to determine maximum medical improvement (MMI) and assign an IR. When the MMI and the range of motion, strength, or sensory testing required assigned an IR for the musculoskeletal body area(s), the doctor should bill using component modifier – WP. The Maximum Allowable is reimbursed at 100%. **We seek full reimbursement for the outstanding balance of $500.00** along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2011	99456-W5-WP	$500.00	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 12, 2011
   - 806-006 – DENIED: PER CARRIER, PROCEDURE DENIED AS A NON-COVERED SERVICE. $0.00 DENIED: PER CARRIER, PROCEDURE DENIED AS A NON-COVERED SERVICE.
   - B1 – NON-COVERED VISITS. $0.00

Issues

1. Is the respondent's denial adjustment reason codes 806-006 and B1 supported?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The respondent denied the billing with reason code "806-006 – DENIED: PER CARRIER, PROCEDURE DENIED AS A NON-COVERED SERVICE. $0.00 DENIED: PER CARRIER, PROCEDURE DENIED AS A NON-COVERED SERVICE" and "B1 – NON-COVERED VISITS. $0.00." The respondent did not clarify or otherwise address or uphold the 806-006 or B1 claim adjustment codes upon receipt of the request for reconsideration or in the dispute resolution response, the Division will review the billing per the applicable Division rules and fee guidelines in 28 Texas Administrative Code §134.204 with the review of supporting documentation.

   The Texas Labor Code §408.0041 states in (h)(1): (h) The insurance carrier shall pay for: (1) an examination required under Subsection (a) or (f) and the Texas Labor Code §408.0041 states in (a)(1)(2): (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any questions about: (1) the impairment caused by the compensable injury; (2) the attainment of maximum medical improvement.

2. The requestor billed the amount of $500.00 for CPT code 99456-W5-WP with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Designated Doctor examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The Division order on the EES-14 and DWC032 form was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the narrative documentation supports that MMI was assigned and 1 body area was rated, the cervical/lumbar spine (spine). Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The Maximum Allowable Reimbursement (MAR) for the Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(I) for the IR using Diagnosis Related Estimates (DRE) Category I method on the compensable cervical/lumbar spine (spine) is $150.00. The combined Maximum Allowable Reimbursement (MAR) for the MMI/IR services rendered is $500.00.

3. The respondent has previously reimbursed the requestor the amount of $0.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is entitled to reimbursement of $500.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 24, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.